Cognitive-behaviour therapy for depersonalisation disorder: an open study

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Abstract

Depersonalisation (DP) and derealisation (DR) are subjective experiences of unreality in, respectively, one’s sense of self and the outside world. These experiences occur on a continuum from transient episodes that are frequently reported in healthy individuals to a chronic psychiatric disorder that causes considerable distress (depersonalisation disorder: DPD). Despite the relatively high rates of reporting these symptoms, little research has been conducted into psychological treatments for this disorder. We report on an open study where 21 patients with DPD were treated individually with cognitive behavioural therapy (CBT). The therapy involved helping the patients re-interpret their symptoms in a non-threatening way as well as reducing avoidances, safety behaviours and symptom monitoring. Significant improvements in patient-defined measures of DP/DR severity as well as standardised measures of dissociation, depression, anxiety and general functioning were found at post-treatment and six-months follow-up. Moreover, there were significant reductions in clinician ratings on the Present State Examination (Wing, Cooper & Sartorius, 1974), and 29% of participants no longer met criteria for DPD at the end of therapy. These initial results suggest that a CBT approach to DPD may be effective, but further trials with larger sample sizes and more rigorous research methodology are needed to determine the specificity of this approach.

Keywords: Depersonalisation disorder; Dissociation; Cognitive-behavioural therapy

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1. Introduction

Depersonalisation (DP) is an experience in which the individual feels a sense of unreality and detachment from themselves. This is often accompanied by the symptom of derealisation (DR) in which the external world also appears unfamiliar (Diagnostic and Statistical Manual of Mental Disorder (DSM-IV), American Psychiatric Association, 1994; ICD-10 Classification of Mental and Behavioural Disorders (ICD-10), World Health Organisation, 1992). Sufferers often describe their experiences of unreality as if they are living in a dream, and their sense of detachment from the world as though they are viewing life from behind glass. These experiences are not delusional since the sufferer retains insight that these are subjective phenomena rather than objective reality.

A review of epidemiological surveys of DP and/or DR (Hunter, Sierra, & David, 2004) found that transient experiences of these phenomena are almost universal in the general population. Moreover, community surveys employing standardised diagnostic interviews to measure clinically significant symptoms of DP/DR reported rates of between 1.2% and 1.7% for a one-month prevalence in two UK samples, and a 2.4% current prevalence rate in a North American sample. Current prevalence rates of disorder in samples of consecutive inpatient admissions are reported to be between 1% and 16%, with prevalence rates in clinical samples of specific psychiatric disorders reaching 83% in the case of panic.

Despite the relatively high rates of reporting of these symptoms, the published literature on psychological treatments for DP/DR is confined to single case studies except for one larger series (Ackner, 1954). In this, neither the therapeutic orientation of the treatment nor the methods used to assess outcome was specified. Case studies reporting successful outcomes have employed psychoanalytical techniques (Torch, 1987), psychoanalysis combined with abreaction by intravenous diazepam (Ballard, Mohan, & Handy, 1992), family therapy (Cattell & Cattell, 1974), behavioural methods (Blue, 1979) and imaginal exposure using tapes of grossly exaggerated narratives of previous DP episodes (Sookman & Solyom, 1978). A major limitation in these studies is that they rely on clinical judgement to assess outcome rather than quantitative methods.

A literature search using Medline, Psychlit and Web of Science databases found no published randomised controlled trials of psychological intervention for DP/DR up to the end of 2003. Consequently, there is no standard treatment protocol and, despite some success with individual cases, the consensus view remains that DPD has a poor prognosis for psychotherapeutic intervention.

A recent cognitive-behavioural conceptualisation of DPD (Hunter, Phillips, Chalder, Sierra, & David, 2003) proposes that the chronic condition of DPD may result from catastrophic misinterpretations of the common, but normally transient, symptoms of DP/DR as indicative of serious mental illness and/or brain dysfunction. These misinterpretations serve to exacerbate and perpetuate the symptoms of DP/DR through the development of a range of cognitive biases and behaviours that form a maintenance cycle. This misinterpretation is similar to the process described in models of panic (Clark, 1986) or health anxiety (Warwick & Salkovskis, 1990). However, the cognitions in each condition may be disorder-specific, with panic and health anxiety patients focusing more on catastrophic misinterpretations of the physical symptoms of anxiety, whereas DPD patients may be more concerned about the cognitive symptoms of anxiety and suffer a form of ‘mental-health anxiety’.
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